

**NOTICE**

**IF YOU HAVE BEEN INJURED AT WORK, YOU MUST FURNISH THE EMPLOYER NAME, PHONE #, AND CONTACT PERSON WHERE YOU REPORTED YOUR INJURY.**

**YOU WILL BE RESPONSIBLE FOR ALL CHARGES UNTIL THIS INFORMATION IS PROVIDED AND WORKERS' COMP COVERAGE IS CONFIRMED.**

**FAILURE TO REPORT YOUR WORK INJURY TO YOUR EMPLOYER PROMPTLY MAY DELAY WORKERS' COMP COVERAGE.**

**WORKERS' COMPENSATION  
AUTHORIZATION FOR TREATMENT**

**Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Date of Accident:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**TO THE PATIENT:** It is necessary that your employer sign the following Authorization for Treatment and return to our office. If not, you will be responsible for payment.

**TO THE EMPLOYER:** I acknowledge the work related injury of the above named patient. You are authorized to render the appropriate care needed for this injury and we will file the proper forms with our insurance carrier.

**Authorized by:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**PLEASE RETURN THIS FORM IMMEDIATELY TO:**

**Doctor's/Clinic Name:** HANSEN CHIROPRACTIC WELLNESS CENTER

**Address:** 1454 Colfax Street

**City, State, Zip:** Blair, NE 68008

**Telephone:** 402 426-3663